

SERFF Tracking Number: AMFA-127007791 State: Arkansas  
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 47865  
Company Tracking Number: GR 125 REV. 1-11 [PDP TRUST]  
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
Product Name: GR 125 Rev. 1-11 [PDP TRUST]  
Project Name/Number: GR 125 Rev. 1-11/GR 125 Rev. 1-11

## Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: GR 125 Rev. 1-11 [PDP TRUST]

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: AMFA-127007791 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 47865

Co Tr Num: GR 125 REV. 1-11 State Status: Approved-Closed  
[PDP TRUST]

Reviewer(s): Rosalind Minor

Authors: Janis Landon, Stephanie  
Mundt Disposition Date: 02/15/2011

Date Submitted: 02/03/2011 Disposition Status: Approved-  
Closed

Implementation Date:

## General Information

Project Name: GR 125 Rev. 1-11

Project Number: GR 125 Rev. 1-11

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Trust

Filing Status Changed: 02/15/2011

State Status Changed: 02/15/2011

Created By: Janis Landon

Corresponding Filing Tracking Number:

Filing Description:

Form - GR 125 Rev. 1-11 [PDP Trust]

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Janis Landon

Dear Sir/Madam:

Enclosed for your review and approval is the above referenced form. This form replaces form WB107 3/04, previously approved by your Department on May 5, 2004 under SERT-5Y8NQS261. The proposed effective date is upon

SERFF Tracking Number: AMFA-127007791 State: Arkansas  
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approval.

This form will be used for those employers wishing to subscribe to a group trust policy which provides dental, orthodontia and vision coverages. The master trust policy, 9000-Trust Rev. 03-08, is issued to the trustees of the Bankers Life Nebraska Preferred Trust, which is situated in the state of Nebraska.

This form has been scored on the Flesch readability scale and scored a 50 when with the policy. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards.

If you should have any questions, please don't hesitate to contact me at 1-800-745-1112, extension 82444, fax 402-309-2573 or email [jlandon@ameritas.com](mailto:jlandon@ameritas.com).

Sincerely,  
Janis Landon, FLMI, ACS  
Senior Contract Analyst

## Company and Contact

### Filing Contact Information

Janis Landon, Senior Contract Analyst [jlandon@ameritas.com](mailto:jlandon@ameritas.com)  
475 Fallbrook Blvd. 800-745-1112 [Phone] 82444 [Ext]  
Lincoln, NE 68521 402-309-2573 [FAX]

### Filing Company Information

Ameritas Life Insurance Corp. CoCode: 61301 State of Domicile: Nebraska  
5900 O Street Group Code: 943 Company Type:  
P O Box 81889 Group Name: State ID Number:  
Lincoln, NE 68501-1889 FEIN Number: 47-0098400  
(800) 756-1112 ext. [Phone]

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: 1 form x \$50.00 = \$50.00

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Project Name/Number: GR 125 Rev. 1-11/GR 125 Rev. 1-11  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	\$50.00	02/03/2011	44343757

<i>SERFF Tracking Number:</i>	<i>AMFA-127007791</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Ameritas Life Insurance Corp.</i>	<i>State Tracking Number:</i>	<i>47865</i>
<i>Company Tracking Number:</i>	<i>GR 125 REV. 1-11 [PDP TRUST]</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>GR 125 Rev. 1-11 [PDP TRUST]</i>		
<i>Project Name/Number:</i>	<i>GR 125 Rev. 1-11/GR 125 Rev. 1-11</i>		

## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Rosalind Minor	02/15/2011	02/15/2011

### Amendments

<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Form	insurance application and subscription to the Janis Landon trust	Janis Landon	02/15/2011	02/15/2011

*SERFF Tracking Number:* AMFA-127007791      *State:* Arkansas  
*Filing Company:* Ameritas Life Insurance Corp.      *State Tracking Number:* 47865  
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*Product Name:* GR 125 Rev. 1-11 [PDP TRUST]  
*Project Name/Number:* GR 125 Rev. 1-11/GR 125 Rev. 1-11

## **Disposition**

Disposition Date: 02/15/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMFA-127007791 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form (revised)	insurance application and subscription to the trust	Approved-Closed	Yes
Form	insurance application and subscription to the trust	Replaced	Yes

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**Amendment Letter**

Submitted Date: 02/15/2011

**Comments:**

We have made a minor change to the application being submitted for approval. Brackets that were in the form number have been replaced with parenthesis.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
GR 125 Rev. 1-11 (PDP Trust)	Application/Enrollment Form	Insurance application and subscription to the trust	Revised		SERT-5Y8NQS261	WB107 3/04	50.000	GR125PDPA pp-021511.pdf

SERFF Tracking Number: AMFA-127007791 State: Arkansas  
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## Form Schedule

### Lead Form Number: GR 125 Rev. 1-11 [PDP Trust]

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR 125 Rev. 1-11	Application/insurance enrollment and subscription to Form	Application/insurance enrollment and subscription to the trust	Revised	Replaced Form #: WB107 3/04 Previous Filing #: SERT-5Y8NQS261	50.000	GR125PDPA pp-021511.pdf

# insurance application and subscription to the trust — subscription agreement



The undersigned employer hereby applies for membership in the Bankers Life Nebraska Preferred Trust and subscribes to, adopts, and agrees to be bound by all the terms and conditions of the declaration of the Trust. It is understood that the Trust must accept the application in writing before membership is approved.

**X** For the Firm By: \_\_\_\_\_  
REQUIRED - APPLICANT'S SIGNATURE Title

## insurance application

Having applied for membership in the Bankers Life Nebraska Preferred Trust, we also hereby elect to participate in the Dental or Dental and Eye Care Program of Ameritas Life Insurance Corp. (hereinafter referred to as the "Company") and meet the terms and conditions of the Group Insurance Policy issued to the Trustees of the Trust. All active full-time employees working at least 30 hours per week are eligible to participate in the dental and eye care insurance plans. Please refer to the participation table and maintenance requirement section of the brochure for specific details.

1. Firm's Legal Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
2. Firm's Federal Tax ID/EIN (otherwise, need applicant's SSN) \_\_\_\_\_
3. Address \_\_\_\_\_  
Street Address City State ZIP
4. Number of Full-Time Employees Eligible (minimum 3): \_\_\_\_\_ Number of Employees with Eligible Dependents: \_\_\_\_\_
5. Eligibility Period:  1 month  2 months  3 months (No eligibility period applies to those employed on the Effective Date.)
6. Nature of Business or Industry: \_\_\_\_\_
7. Please provide coverage for:  Employee only  Employee and dependents
8. Are any Subsidiary or Affiliated Companies to be Insured?  Yes  No (If Yes, list on separate sheet)
9. Requested Effective Date: (Must be first of month) \_\_\_\_\_

When approved, the insurance shall be effective at 12:01 A.M. Standard Time at the Applicant's address.

10. Requesting:  Plan A - \_\_\_\_\_ (Traditional dental, optional eye care)  Plan B - \_\_\_\_\_ (Cost-containment dental, child ortho)  Plan C - \_\_\_\_\_ (Traditional dental with PPO, eye exam-only)
11. Focus eye care option included (Plan A)?  Yes  No Add Focus eye care option to current PDP Plan?  Yes  No
12. Have you ever before had a dental plan with the Company?  Yes  No If Yes, policy number \_\_\_\_\_
13. Requested billing option:  Monthly  Quarterly
14. The employer agrees to contribute toward the overall cost of insurance, the following percentages:  
 For employee \_\_\_\_\_ %. For dependents \_\_\_\_\_ %. (Minimum contribution is 25% of the total monthly or quarterly premium.)
15. Takeover Dental - Plans A, B and C (minimum 3 enrolled employees and 12 months' prior coverage)  Yes  No If Yes, provide a, b, c, d, e.  
 Takeover Ortho - Plan B (minimum 3 enrolled employees and 12 months' prior coverage)  Yes  No If Yes, provide a, b, c, d, e.  
 a) Name of Carrier \_\_\_\_\_ d) Policy Number \_\_\_\_\_  
 b) Effective Date of Prior Plan \_\_\_\_\_ e) Proof of prior coverage is required. Submit prior invoice,  
 c) Termination Date \_\_\_\_\_ certificate of acceptance, and risk letter or policy.

THE APPLICANT UNDERSTANDS that he or she, and not the Company nor the Trustees, is the Plan Administrator and Fiduciary (as defined in the Employee Retirement Income Security Act of 1974, Public Law 93-406). THE APPLICANT REPRESENTS that he or she has read the statements and the answers to the above questions and that they are complete and true to the best of his or her knowledge. The Applicant agrees that this application is made to induce the Company to issue the insurance applied for; such insurance to be in the amounts agreed upon by the Company and the Applicant. Group insurance at the Company's rates and under the terms of the policy(ies) applied for shall take effect on the date shown in Number 9, if this application is accepted by the Company. If this application is not accepted, any premium advanced by the Applicant shall be refunded. The Company reserves the right to reject any case which, in its opinion, does not conform to sound underwriting criteria. No insurance is in force until written acceptance is received. THE APPLICANT CERTIFIES that the exclusions and limitations contained in the limitations sections in this brochure to which this application is attached have been thoroughly explained to him/her and the Applicant understands their significance. THE APPLICANT UNDERSTANDS that the agent identified under Producer Information is, for the purposes of this dental program only, affiliated with the Company as its sales representative. The Applicant also understands that as compensation for services rendered, the sales representative receives 10% of the annual premium paid by the Applicant for this dental program.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ month, \_\_\_\_\_ year. Dated at \_\_\_\_\_  
(City and State)

**X** For the Firm By: \_\_\_\_\_  
REQUIRED - AUTHORIZED EMPLOYER SIGNATURE Print Name Title

## acceptance by Bankers Life Nebraska Preferred Trust

The above subscriber is hereby accepted as a member of the Bankers Life Nebraska Preferred Trust effective month/day \_\_\_\_\_, year \_\_\_\_\_, and receipt of the first monthly premium is acknowledged.

Date Accepted \_\_\_\_\_ By \_\_\_\_\_  
Ameritas Life Insurance Corp. for the Trustees

Policy Number \_\_\_\_\_ Division Number \_\_\_\_\_

**In several states, we are required to advise you of the following:** Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment.

In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State specific statements below.)

**Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

**No Cost Language Services.** You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

**Servicios de idiomas sin costo.** Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

**Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Note for D.C. Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Note for New Mexico and Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Note for Texas Residents:** Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

**Note for Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for North Carolina Residents:** After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

<i>SERFF Tracking Number:</i>	<i>AMFA-127007791</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>GR 125 REV. 1-11 [PDP TRUST]</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>GR 125 Rev. 1-11 [PDP TRUST]</i>		
<i>Project Name/Number:</i>	<i>GR 125 Rev. 1-11/GR 125 Rev. 1-11</i>		

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	02/15/2011
<b>Comments:</b>			
<b>Attachment:</b>			
readability-alic - AR.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	02/15/2011
<b>Bypass Reason:</b>	Application being filed in this filing.		
<b>Comments:</b>			

**STATE OF ARKANSAS**  
**CERTIFICATE OF READABILITY**

INSURER:

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:

FLESCH SCORE:

FORM NAME:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: \_\_\_\_\_

TYPED NAME:

TITLE:

DATE: \_\_\_\_\_

<i>SERFF Tracking Number:</i>	<i>AMFA-127007791</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Ameritas Life Insurance Corp.</i>	<i>State Tracking Number:</i>	<i>47865</i>
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## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
01/28/2011	Form	insurance application and subscription to the trust	02/15/2011	GR125PDPApp.pdf (Superseded)

# insurance application and subscription to the trust — subscription agreement



The undersigned employer hereby applies for membership in the Bankers Life Nebraska Preferred Trust and subscribes to, adopts, and agrees to be bound by all the terms and conditions of the declaration of the Trust. It is understood that the Trust must accept the application in writing before membership is approved.

**X** For the Firm By: \_\_\_\_\_  
REQUIRED - APPLICANT'S SIGNATURE Title

## insurance application

Having applied for membership in the Bankers Life Nebraska Preferred Trust, we also hereby elect to participate in the Dental or Dental and Eye Care Program of Ameritas Life Insurance Corp. (hereinafter referred to as the "Company") and meet the terms and conditions of the Group Insurance Policy issued to the Trustees of the Trust. All active full-time employees working at least 30 hours per week are eligible to participate in the dental and eye care insurance plans. Please refer to the participation table and maintenance requirement section of the brochure for specific details.

1. Firm's Legal Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
2. Firm's Federal Tax ID/EIN (otherwise, need applicant's SSN) \_\_\_\_\_
3. Address \_\_\_\_\_  
Street Address City State ZIP
4. Number of Full-Time Employees Eligible (minimum 3): \_\_\_\_\_ Number of Employees with Eligible Dependents: \_\_\_\_\_
5. Eligibility Period:  1 month  2 months  3 months (No eligibility period applies to those employed on the Effective Date.)
6. Nature of Business or Industry: \_\_\_\_\_
7. Please provide coverage for:  Employee only  Employee and dependents
8. Are any Subsidiary or Affiliated Companies to be Insured?  Yes  No (If Yes, list on separate sheet)
9. Requested Effective Date: (Must be first of month) \_\_\_\_\_

When approved, the insurance shall be effective at 12:01 A.M. Standard Time at the Applicant's address.

10. Requesting:  Plan A - \_\_\_\_\_ (Traditional dental, optional eye care)  Plan B - \_\_\_\_\_ (Cost-containment dental, child ortho)  Plan C - \_\_\_\_\_ (Traditional dental with PPO, eye exam-only)
11. Focus eye care option included (Plan A)?  Yes  No Add Focus eye care option to current PDP Plan?  Yes  No
12. Have you ever before had a dental plan with the Company?  Yes  No If Yes, policy number \_\_\_\_\_
13. Requested billing option:  Monthly  Quarterly
14. The employer agrees to contribute toward the overall cost of insurance, the following percentages:  
 For employee \_\_\_\_\_%. For dependents \_\_\_\_\_%. (Minimum contribution is 25% of the total monthly or quarterly premium.)
15. Takeover Dental - Plans A, B and C (minimum 3 enrolled employees and 12 months' prior coverage)  Yes  No If Yes, provide a, b, c, d, e.  
 Takeover Ortho - Plan B (minimum 3 enrolled employees and 12 months' prior coverage)  Yes  No If Yes, provide a, b, c, d, e.  
 a) Name of Carrier \_\_\_\_\_ d) Policy Number \_\_\_\_\_  
 b) Effective Date of Prior Plan \_\_\_\_\_ e) Proof of prior coverage is required. Submit prior invoice,  
 c) Termination Date \_\_\_\_\_ certificate of acceptance, and risk letter or policy.

THE APPLICANT UNDERSTANDS that he or she, and not the Company nor the Trustees, is the Plan Administrator and Fiduciary (as defined in the Employee Retirement Income Security Act of 1974, Public Law 93-406). THE APPLICANT REPRESENTS that he or she has read the statements and the answers to the above questions and that they are complete and true to the best of his or her knowledge. The Applicant agrees that this application is made to induce the Company to issue the insurance applied for; such insurance to be in the amounts agreed upon by the Company and the Applicant. Group insurance at the Company's rates and under the terms of the policy(ies) applied for shall take effect on the date shown in Number 9, if this application is accepted by the Company. If this application is not accepted, any premium advanced by the Applicant shall be refunded. The Company reserves the right to reject any case which, in its opinion, does not conform to sound underwriting criteria. No insurance is in force until written acceptance is received. THE APPLICANT CERTIFIES that the exclusions and limitations contained in the limitations sections in this brochure to which this application is attached have been thoroughly explained to him/her and the Applicant understands their significance. THE APPLICANT UNDERSTANDS that the agent identified under Producer Information is, for the purposes of this dental program only, affiliated with the Company as its sales representative. The Applicant also understands that as compensation for services rendered, the sales representative receives 10% of the annual premium paid by the Applicant for this dental program.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ month, \_\_\_\_\_ year. Dated at \_\_\_\_\_  
(City and State)

**X** For the Firm By: \_\_\_\_\_  
REQUIRED - AUTHORIZED EMPLOYER SIGNATURE Print Name Title

## acceptance by Bankers Life Nebraska Preferred Trust

The above subscriber is hereby accepted as a member of the Bankers Life Nebraska Preferred Trust effective month/day \_\_\_\_\_, year \_\_\_\_\_, and receipt of the first monthly premium is acknowledged.

Date Accepted \_\_\_\_\_ By \_\_\_\_\_  
Ameritas Life Insurance Corp. for the Trustees

Policy Number \_\_\_\_\_ Division Number \_\_\_\_\_

**In several states, we are required to advise you of the following:** Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment.

In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State specific statements below.)

**Note for California Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. For policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

**No Cost Language Services.** You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

**Servicios de idiomas sin costo.** Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

**Note for Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Note for D.C. Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Note for Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Note for New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Note for New Mexico and Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Note for Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Note for Texas Residents:** Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

**Note for Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Note for North Carolina Residents:** After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.